ELSEVIER
www.rhm-elsevier.com

© 2005 Reproductive Health Matters.
All rights reserved.
Reproductive Health Matters 2005;13(26):13–19
0968-8080/05 $ – see front matter
PII: S0968-8080(05)26217-1

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

DISCUSSION

Introducing Medical Abortion within the Primary Health System: Comparison with Other Health Interventions and Commodities

Sharad D Iyengar

Secretary, Action Research & Training for Health (ARTH), Udaipur, India. E-mail: arth@softhome.net

Abstract: *Over the years, a de-medicalisation strategy has been adopted for a range of public health interventions and commodities for the reduction of mortality, morbidity and population growth, including those for reproductive, neonatal and child health, communicable diseases, and trauma and emergency care, as a way of enhancing access to essential services. These experiences carry valuable lessons for de-medicalising and simplifying the provision of medical abortion. Like the combined oral pill and emergency contraception, which have become non-prescription drugs despite strident opposition, the abortion pill fundamentally alters the relationship between women and their health care providers. Measures for de-medicalising primary health services include adoption of simpler technology and service protocols, authorisation and training of less qualified providers, simplification or elimination of facility requirements, establishment of robust referral links to hospitals, increasing user control and self-medication, and simplifying arrangements for financing. By applying these measures, medical abortion can be widely provided as a primary health care service. To enable this, however, laws and policies must move beyond the surgical abortion paradigm, drugs must become reliably available at affordable cost, and women must have access to information that de-stigmatises abortion, enhances their options and aims to balance the power between them and their health care providers.* © 2005 Reproductive Health Matters. All rights reserved.

Keywords: medical abortion, primary health care services, de-medicalisation, health interventions and commodities

THOSE living in interior areas of developing countries, especially women lacking physical and social mobility, have no option but to rely on weakly governed primary health systems, whether delivered by public or private providers, for meeting their basic health needs. Despite an emphasis on primary health care in the 1978 Alma Ata declaration, under-investment and poor governance continue to impede the delivery of any health intervention through the primary health system, be it for malaria, tuberculosis, child health, family planning or unwanted pregnancy. Where access to rational primary health services in the interior areas of developing countries is poor, untrained or semi-trained health workers provide quick cures using high doses and irrational combinations of mostly injectable drugs.[1,2]

This situation tends to co-exist with the ready availability of sophisticated hospital-based services in cities of the region – both are the result of rigid regulatory systems that encourage over-medicalisation of health services in the name of safeguarding an alien standard of quality that has not been adapted to local conditions. Over-medicalisation justifies over-investment in services for the few who manage to reach urban hospitals, while ignoring lack of services for the

rest. It draws legitimacy from experts who populate apex medical institutions and professional associations, and is mediated through norms and regulations governing facilities, providers, training, technology and service protocols. Violation of these norms exposes providers or their organisations to the risk of legal action, with courts tending to rely on the opinion of the very same experts in determining whether and how standards were violated. However, where the enforcement of laws and regulations is weak, as in the rural interiors and urban slums, a primary health underworld thrives on the need for essential services among the poor. Among the most lucrative of informal primary health services is the management of a missed period or unwanted pregnancy.[3]

While there is no contesting the need to strengthen primary health systems as a medium- to long-term equity measure, access to essential health services can be rapidly increased by adapting health technology to the needs of disadvantaged communities. The chief adaptation strategy has been one of de-medicalising health care, which may be simply understood as systematic measures undertaken by a health programme to optimise the need for scarce or expensive medical resources. As a consequence, the regulatory environment, technology, human resources and management systems are altered in a coordinated manner, so as to enhance access to services without compromising quality. This has been done for a diverse range of health interventions, including those for tuberculosis, malaria, child survival and trauma.[4–7] These experiences carry valuable lessons for the introduction of medical abortion within primary health systems.

Public health goals and the political response to these goals have deeply influenced the ease or difficulty with which health technology has been introduced or its use has been scaled up. Large scale interventions for controlling communicable diseases like tuberculosis and malaria, and those for maternal and child health have all been driven by goals of reducing disease burden, mortality and morbidity.[8–10] The emergence of modern threats to life and health, such as road traffic injuries and coronary heart disease, has in turn spurred investments in cities on trauma and emergency services.[11] In the field of reproductive health, national and international goals for controlling rapid population growth have been prioritised through heavy investment in family planning programmes.[12] Disasters and refugee crises have in turn galvanised action across countries. A critical level of political consensus has underpinned all these goals, and most have gained active support from governments. In sharp contrast, where the goal has been to enable women to avoid unwanted births by providing safe abortion services, governments and regulatory authorities have been slow or unwilling to make abortion technology and providers easily available at the primary health level, for political and ideological rather than scientific reasons.

This paper reviews significant events in the introduction of an array of primary health interventions and commodities, their underlying ideology, and the applicability of these experiences to the situation of medical abortion. These cover programmes for maternal and neonatal and child health, control of tuberculosis, malaria and HIV/AIDS, reproductive health, trauma and emergency care.

Regulation and licensing

The licensing of two reproductive health commodities – the combined oral contraceptive pill and the emergency contraceptive pill – throws light on how regulators have responded to health and rights considerations. The history of the registration of oral contraceptives in the US and UK reveals that drug regulatory authorities balanced concerns about the safety of the early pill with its demonstrated efficacy.[13] In 1957, GD Searle registered the first combined pill (Enovid) in the US, for the treatment of a range of gynaecologic conditions including dysmenorrhoea, menorrhagia and endometriosis. Only in 1960 was Enovid additionally registered as a contraceptive, notwithstanding a hands-off approach on the part of government and frank opposition from the Catholic Church. By then, thousands of women were already using it through off-label prescription as a birth control pill. Today, the low-dose combined oral pill is available as an over-the-counter product, and minimally trained community-level workers distribute it in several developing countries.[14] In a similar scenario, up to 37 countries now allow the emergency contraceptive pill to be used without prescription and many more are discussing doing so.[15] Those who have refused to do so, including the US and

the Philippines (where the method has even been banned), are doing so due to pressure from fundamentalist lobbies, not for reasons of safety or efficacy.[16]

Most of the arguments in favour of the combined pill and emergency contraception could also be marshalled to further the case of the abortion pill. However, the registration of mifepristone met with indifference from its original manufacturer and opposition from several governments. Meanwhile, despite increasing evidence of efficacy when used alone, misoprostol has faced opposition in some countries and has been banned in a few, again for ideological reasons.[16] Like the combined oral and emergency contraceptive pills, the abortion pill fundamentally alters the relationship between women and their physicians or service providers. Time will tell whether medical abortion will eventually go the same way in terms of liberal access for women.

Experience with simplifying and de-medicalising primary health services

Measures for de-medicalising primary health services have included adoption of simpler technology and service protocols, authorisation and training of less qualified providers, simplification or elimination of facility requirements, establishment of robust referral links to hospitals, reducing the asymmetry of information between women and their providers, increasing user-control and self-medication and simplifying arrangements for financing.

Technology

Simpler, lower-technology devices and methods have replaced the more complex. For example, the partograph guides skilled attendants on when to refer for prolonged labour, oral rehydration salts have replaced intravenous fluids as treatment for dehydration following diarrhoea, visual inspection using acetic acid or Lugol's iodine shows promise as an alternative to Pap smears for cervical screening, and rapid HIV tests have been developed for low-resource settings.[17–19] Drug and medical supply kits for use during natural disasters and refugee crises allow for a range of on-the-spot treatments, including emergency contraception for rape and sexual assault.[20] Several advances have simplified safe abortion technology – vacuum aspiration does not require general anaesthesia and manual vacuum aspiration (MVA) works without electricity, while medical abortion pills can literally replace surgery for a large proportion of women.

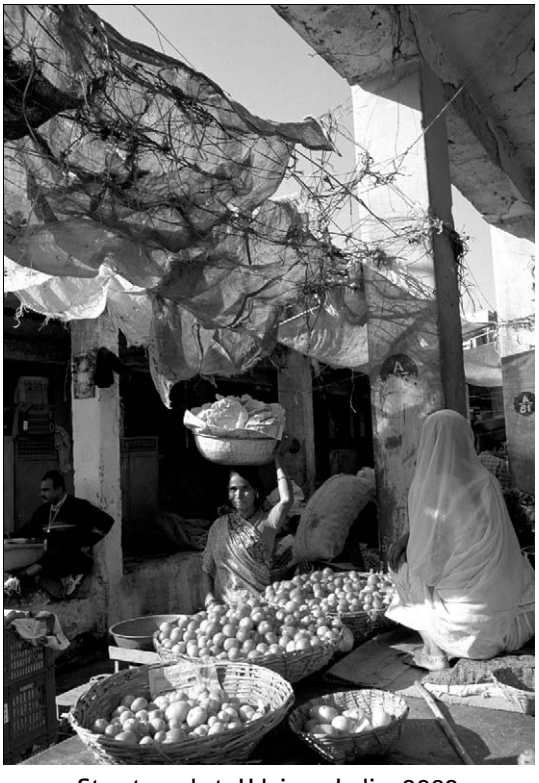
Providers

At another level, the process of de-medicalisation has meant authorising less qualified providers to use registered drugs. Malaria programmes in several countries have authorised community volunteers and paramedics to use chloroquine, and are considering doing the same for newer antimalarial drugs.[5,21,22] On another note, once it was demonstrated that health workers could be trained to recognise pneumonia in children by observing and counting their breathing without the help of a doctor or stethoscope, child health programmes started allowing health workers to dispense the antibiotic co-trimoxazole with positive impact on pneumonia mortality.[23] More recently, nursing and midwifery personnel in many developing countries have been trained and authorised to evacuate the uterus and to use oxytocics, antibiotics, magnesium sulfate or intravenous fluids for managing pregnancy-related complications.[24] In urban areas, trained paramedics staffing mobile critical care units stabilise patients suffering from trauma, strokes or myocardial infarct, while community-based volunteers working in rural or slum communities distribute de-worming tablets to children and oral contraceptive pills to women.[11,14]

In the case of abortion, however, countries have been far more restrictive – few have yet allowed mid-level providers to use MVA for inducing abortion, while abortion pills are licensed only to physicians to dispense, despite their being much simpler to use.[25]

Facilities

Facility requirements have been simplified or eliminated in an attempt to increase access to services. Examples include the use of simple birthing centres even in developed countries, allowing midwives to conduct normal deliveries, the establishment of blood storage centres in place of blood banks in rural areas, the use of portable vaccine carriers and disposable syringes for mass immunisation in the community, and doorstep delivery of tuberculosis drugs, injectable and oral contraceptives.[26]



FEDINANDO SCIANNA / MAGNUM PHOTOS

Street market, Udaipur, India, 2003

Electric or manual vacuum aspiration for first trimester abortion requires minimal arrangements for privacy and aseptic aspiration. Unlike surgical methods, abortion pills induce a process of change from a pregnant to a non-pregnant state, for which a basic clinic facility suffices and which has been proven to take place safely at home up to nine weeks of pregnancy. Unfortunately, laws and regulations governing the provision of abortion services in most countries continue to be rooted in the regulated facility paradigm.

Protocols

Health programmes have innovated simpler ways of screening clients for taking decisions on providing services. For example, a health worker can administer checklists to determine a woman's medical eligibility for adopting oral pills or IUDs. Fast breathing and chest in-drawing have been researched as markers of moderate and severe pneumonia and health workers have successfully been trained to recognise them.[23] Taking the process further, standard case management protocols have been developed for a range of primary health conditions, including chloroquine for fever in malaria endemic areas, IMCI (Integrated Management of Childhood Illness), IMPAC (Integrated Management of Pregnancy and Childbirth) and syndromic management of sexually transmitted infections.[17,27,28] Alternate-day dosing and short course-treatment for treating tuberculosis have helped to reduce follow-up visits.

In the same vein that pregnancy can be confirmed using a combination of simple clinical criteria and a urine pregnancy test, standard protocols for medical abortion would allow any trained health provider to deliver the service and the number of visits can be reduced by allowing home use of misoprostol.

Referral

By design, the wider use of less qualified primary health workers to stabilise maternal or neonatal complications or treat seriously ill children has necessitated robust referral linkage to hospitals.[17,27] Formal arrangements should be established in advance between the primary and secondary health systems. In particular, hospitals receiving such referrals should be prepared to deal with instances of over-referral and inappropriate referral – these can and do occur because referral protocols are designed to err on the side of safety. Furthermore, a health worker in an isolated setting might become overwhelmed by the appearance of (what seems to be) a serious complication.[29] The reflex tendency of hospital doctors and nurses to disparage the actions of referring health providers needs to be guarded against, since it demoralises patients' families, jeopardises future referrals and damages the entire programme.

A primary health programme that provides medical abortion can offer MVA as back-up and also manage most complications. However, a few women with complications such as haemorrhage might need referral; hence these cautions would apply to them too.

Control

Even while serving a valid purpose, certain kinds of health technology, including general or regional anaesthesia, surgical procedures, immobilisation devices such as plaster casts and contraceptive implants strengthen control by the provider. By contrast, certain other kinds of technology tend

to alter the traditional provider–patient power relationship, by allowing the user far greater control and options over time. These include self-medication devices – peak-flow meters and inhalers for asthma, glucometers and insulin injections for diabetes, combined oral and emergency contraceptive pills, urine pregnancy tests and the abortion pill.

In matters of sexuality, however, moral and ideological authority has been mediated through control over technology – for example, women seeking abortion out-of-wedlock might be penalised or over-charged. Loss of provider control and income, resulting from increased preference for medical over surgical abortion, might provoke resistance that must be anticipated while introducing it within the health system.

Communication

Only in recent years has better communication with service users been emphasised in practical terms. Training programmes for health providers on family planning, IMCI and HIV testing have all called for inter-personal communication and counselling skills in an attempt to enable people to decide on the course of action, while focused ethnographic research has been used, for example, to identify local terms for pneumonia and respiratory diseases in order to inform patients more fully of their condition.[23] Front-line providers, especially those trained as paramedics, often tend to comprehend and work only in the regional or national language. Training and technical instructional material for them must therefore be available in a language they can use.

The use of simple messages and materials in the local language are similarly important, so that women seeking abortion, especially medical abortion, can exercise an informed choice of abortion method.

Information

Rural and interior communities that lack exposure to modern media tend to place greater value on collective experience while taking decisions on seeking care. Until or unless a critical mass of experience accumulates, however, the health provider might be the only source of information. In the absence of sources of information other than the provider, the person is unable to exercise real choice. This applies especially to situations in which care-seeking is accompanied by high levels of desperation (for example, among persons with untreated tuberculosis, infertility or unwanted pregnancy), and the provider–patient relationship has become potentially exploitative.

Asymmetry of information can reinforce an asymmetric power relationship and narrow women's options. The flow of information tends to be restricted even more so, on abortion for example, in legally restrictive environments. As with other vital primary health services, information on medical abortion should additionally be delivered through channels independent of the service provider or organisation.

Costs

The cost of primary health services is a key determinant of their utilisation. Recognising the crippling burden imposed on poor families by direct and opportunity costs of treating tuberculosis, and the consequences in terms of poor compliance and increased disease transmission, free drugs have been provided under the DOTS initiative.[8] Many countries offer free routine and emergency contraceptive services. Similarly, it is well accepted that immunisation and treatment of sick children should be free. Safe abortion services, however, tend to remain outside the pale of public sector financing – only the UK and some European countries finance abortion services or reimburse costs through health insurance. The total cost of medical abortion must factor in the cost of the drugs and of surgical intervention if indicated. Then there are the opportunity costs of seeking abortion – repeated visits to the provider for medical abortion can escalate both financial and social costs unnecessarily.

Conclusions

The experience of adapting and de-medicalising health technology and interventions has several pointers for the introduction of medical abortion as a primary health service. The abortion pill is a low-technology commodity that can be used under the guidance of a non-physician provider working out of a simple facility. Medical abortion lends itself to standard case management with a high degree of home use, while few of its complications need emergency referral. Women seeking a greater degree of control over the abortion process can opt for medical abortion, provided they have access to provider-independent

channels of objective information. All these attributes make it feasible for medical abortion to be delivered through the primary health system. To enable this, however, the relevant laws and policies must grow beyond the paradigm of surgical abortion, drugs must become reliably available at affordable cost, primary health providers must be trained and authorised in large numbers, referral arrangements must be formalised and service guidelines must recognise women's convenience and give them greater control over the process.

Acknowledgement

The author gratefully acknowledges the assistance of Ms Preeti Roy, Research Supervisor, ARTH, Udaipur, in reviewing the literature for this paper.

References

1. Hanson K, Goodman C, Lines J, et al. The Economics of Malaria Control Interventions. Geneva: Global Forum for Health Research, 2004. p.3–10.
2. Sringernyuang L, Hongvivatana T, Pradabmuk P. Community health workers and drugs (A case study of Thailand). Geneva: World Health Organization, 1995. p.17–26.
3. Rogo K, Bohmer L, Ombaka C. Community level dynamics of unsafe abortion in western Kenya and opportunities for prevention (Summary of findings and recommendations from pre-intervention research). San Francisco: Pacific Institute for Women's Health, 1999. p.8–12.
4. Hanson C. Expanding DOTS in the context of a changing health system. Geneva: World Health Organization, 2003. p.15–52.
5. World Health Organization. World Malaria Report 2005. Geneva: WHO, 2005. At: <http://rbm.who.int/wmr2005/html/2-1.htm> . Accessed 9 September 2005.
6. Bryce J, el Arifeen S, Pariyo G, et al. Reducing child mortality: can public health deliver? Lancet 2003;362(9378):159–64.
7. World Health Organization. The fundamentals. In: Peden M, Scurfield R, Sleet D, editors. World Report on Road Traffic Injury Prevention. Geneva: WHO, 2004. p.3–25.
8. World Health Organization. Towards a TB-free Future. Geneva: WHO, 2002. p.9–45.
9. World Health Organization. Looking Forward (Roll Back Malaria). Geneva: WHO, 2004. p.3–16.
10. World Health Organization. Mothers and children matter – so does their health. In: World Health Report. Geneva: WHO, 2005. p.1–13.
11. Sudden cardiac arrest: a treatable public health crisis. Communicore, Seattle, WA, 1996. At: <publicsafety.tufts.edu/ems/aed/sca_whtp.pdf>. Accessed 9 September 2005.
12. Rao M. Red herrings: Malthusianism and neo-Malthusianism. From Population Control to Reproductive Health: Malthusian Arithmetic. New Delhi: Sage Publications India, 2004. p.75–122.
13. Junod SW, Marks L. Women's trials: the approval of the first oral contraceptive pill in the United States and Great Britain. Journal of the History of Medicine 2002;57:117–60.
14. Helping Women Use the Pill. Population Reports 2000;28(2): Series A, Number 10 (Oral Contraceptives). At: <http://www.infoforhealth.org/pr/a10/a10chap6_2.shtml>. Accessed 9 September 2005.
15. Weiss D. A brief history of emergency hormonal contraception. Planned Parenthood Federation of America, 2005. At: <www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/ec/fact-emergency-contraception-history.xml>. Accessed 5 September 2005.
16. Beleo S (PRID). Solon moves to ban abortive drug, IUDs. Congress of the Philippines House of Representatives. At: <www.congress.gov.ph>. Accessed 9 September 2005.
17. World Health Organization. Integrated Management of Pregnancy and Childbirth: Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice. Geneva: WHO, 2003.
18. Sankaranarayanan R, Gaffikin L, Jacob M, et al. A critical assessment of screening methods for cervical neoplasia. International Journal of Gynecology & Obstetrics 2005; 89:S4–S12.
19. World Health Organization. Rapid HIV tests: Guidelines for Use in HIV Testing and Counselling Services in Resource-Constrained Settings. Geneva: WHO, 2004.
20. World Health Organization. The New Emergency Health Kit 98. WHO/DAP/98.10. Geneva: WHO, 1998.
21. Kidane G, Morrow RH. Teaching mothers to provide home treatment of malaria in Tigray, Ethiopia: a randomized trial. Lancet 2000;356:550–55.
22. Sirima SB. Early treatment of childhood fevers with pre-packaged anti-malarial drugs in the home reduces severe malaria morbidity in Burkina Faso. Tropical Medicine and International Health 2003;8: 1–7.
23. Evidence base for community management of pneumonia

(June 11-12, 2002), Stockholm, Sweden. At: <www.unicef.org/programme/cimci/assets/Stockholm%20mtg,%20final%20report.doc>. Accessed 9 September 2005.
24. Family Care International. Skilled care during childbirth: country profiles. New York: FCI, 2002.
25. Ipas and IHCAR. Deciding women's lives are worth saving: expanding the role of mid-level providers in safe abortion care. Chapel Hill, NC: Ipas, 2002. p.10–30.
26. Action plan for blood safety. National AIDS Control Organization, Ministry of Health & Family Welfare, Government of India, 2003. At: <www.naco.nic.in>. Accessed 9 September 2005.
27. Gove S. Integrated management of childhood illness by outpatient health workers: technical basis and overview. Bulletin of World Health Organization 1997;75(Suppl.1): 7–24.
28. World Health Organization. Sexually Transmitted and Other Reproductive Tract Infections: A Guide to Essential Practice. Geneva: WHO, 2005.
29. Kalter HD, Schillinger JA, Hossain M. Identifying sick children requiring referral to hospital in Bangladesh. Bulletin of World Health Organization 1997;75(Suppl.1): 65–76.

Résumé

Avec le temps, une stratégie de démédicalisation a été appliquée à plusieurs interventions et services de santé publique pour la réduction de la mortalité, la morbidité et la croissance démographique, notamment en matière de santé génésique, néonatale et infantile, maladies transmissibles, et soins en cas de traumatisme et d'urgence, comme méthode pour élargir l'accè aux services essentiels. Ces expériences peuvent inspirer la démédicalisation et la simplification de l'avortement médicamenteux. Comme la pilule contraceptive et la contraception d'urgence, qui sont désormais délivrées sans ordonnance malgré une opposition farouche, la pilule abortive modifie fondamentalement la relation entre les femmes et leurs praticiens. Pour démédicaliser les services de santé primaires, on peut adopter des technologies et des protocoles de prestations plus simples, agréer et former des praticiens moins qualifiés, réduire ou éliminer les conditions imposées aux centres, créer des réseaux aiguillant les patientes vers les hôpitaux, encourager davantage de contrôle et d'automédication chez les usagers, et simplifier les dispositifs de financement. Ces mesures permettraient d'assurer largement l'avortement médicamenteux comme service de santé primaire. Néanmoins, pour y parvenir, il faut que les lois et les politiques dépassent le paradigme de l'avortement chirurgical, que l'approvisionnement en médicaments soit régulier et d'un prix abordable, et que les femmes aient accès à des informations qui déstigmatisent l'avortement, multiplient leurs options et équilibrent leurs pouvoirs et ceux des praticiens.

Resumen

A lo largo de los años, se ha adoptado una estrategia de desmedicalización para una variedad de intervenciones e insumos de salud pública destinados a disminuir la morbimortalidad y el crecimiento de la población, incluidos aquellos relacionados con la salud reproductiva, neonatal e infantil, las enfermedades transmisibles, y el trauma y la atención de urgencia, a fin de mejorar el acceso a los servicios esenciales. Estas experiencias son valiosas lecciones para desmedicalizar y simplificar la prestación de servicios de aborto con medicamentos. Al igual que la píldora oral combinada y la anticoncepción de emergencia, que ahora se venden sin receta pese a la oposición estridente, la píldora abortiva altera fundamentalmente la relación entre la mujer y su prestador de servicios de salud. Algunas medidas para desmedicalizar los servicios de primer nivel son adoptar una tecnología y protocolos más sencillos, autorizar y capacitar a los proveedores menos calificados, simplificar o eliminar los requisitos de las unidades de salud, establecer vínculos de referencia a los hospitales, aumentar el control y el automedicamento de las usuarias, y simplificar los planes de financiación. Al aplicar estas medidas, se puede ampliar la disponibilidad de los servicios de aborto con medicamentos en el primer nivel de atención. Para ello, las leyes y políticas deben trascender el paradigma del aborto quirúrgico, los fármacos deben estar disponibles a precios asequibles, y las mujeres deben tener acceso a información que desestigmatice el aborto, mejore sus opciones y ayude a equilibrar el poder entre ellas y sus proveedores.